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THE CANDIDAN MEDICAL ASSOCIATION
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Manitoba Medical Association

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Memorandum of the Proposed Amalgamation of the Manitoba Medical Association and the College of Physicians and Surgeons of Manitoba

Secretary's Note.—The following memorandum, pursuant to the amalgamation of the Manitoba Medical Association and the College of Physicians and Surgeons of Manitoba, has been prepared and submitted by one of the members of the joint committee. We are having same published in the hope that all members of the profession will give it careful consideration and express to us, by letter, their comments on it.

Constructive criticism is requested. Any individual physician who wishes to comment can be assured that his name will be held confidentially, and will not be divulged even to the members of the committee.—F. W. Jackson.

YOUR Committee, with the understanding that their appointment has been brought about largely by reason of an existing dissatisfaction with, and criticism of the present duplication and overlapping of the business activities of the two organizations, with consequent undue expense and inefficiency resulting from the absence of agreement, or other understanding of the exact limits of the duties of these separate organizations, feel that the purpose of their appointment may best be met by a careful review of all the circumstances and facts regarding the present business activities of the two organizations; and by the determination as to how these, together with the social, educational and scientific interests of the united medical profession of Mani-

toba may best be cared for and carried out; and by the making of such recommendations as may be considered necessary to the reaching of an agreement between the two bodies as to the desired correlation of their work and allotment of their functions.

That the present system of dual organization allows of duplication of services, overlapping of activities, and of a financial outlay which whether excessive or not, is at least not so expended as to obtain the greatest return in efficiency, may be taken for granted; on the basis of the maintenance by each organization of salaried officials, clerical assistants, offices, etc., but above all by the entire lack of any definite understanding by the general membership of the profession, or by the officers of the organizations themselves, as to what privileges and duties apply to each; and by the possibly inescapable tendency of each body to consider that any given activity is the duty of the other, or conversely, that the other is unduly intruding into matters of its own prerogative.

Under these premises and in view of the undoubted desire of every member of the Executive Committee or Council of these two bodies to so conduct business and formulate policies as to be wholly in the interest of the whole profession; it would seem to be a simple matter to so allot the function of these two bodies as to result in an amicable smooth working of either a common or closely associated organization.

Certain difficulties will, however, have to be considered, and certain adjustments and changes made in order to obtain this desired objective.

In the consideration of these, various methods of procedure may be considered which may be grouped under four main headings.

1. **Amalgamation or Actual Union.**

The difficulty here is the legal status and function of the College of Physicians and Surgeons, with the necessity of its continued existence, under its own name, as a licensing and disciplinary body, as provided for under the Medical Act; so that any actual union of the two bodies would of necessity simply mean the cessation of the existence of the Manitoba Medical Association.

That this would be a deplorable solution will be granted by all, in view of the long years of valuable and valued functioning of this body as a voluntary organization of great and increasing influence on the public life of the province; and in view of the close association by affiliation between it and the Canadian and British Medical Association; and in view of its sponsorship and support under its organization of the District Medical Societies of the Province; and in view of its very definite and distinct opportunity for service to the medical profession as a whole in its social, educational and scientific activities.

2. **Close Co-operation by Agreement with Actual Amalgamation of Executive Offices.**

This is the solution most commonly advanced, wherein the proposal is made that the two bodies combine in so far as is concerned in the collection of a common fee and the appointment of an executive officer to act as Registrar of the College of Physicians and Surgeons, and Secretary of the Manitoba Medical Association with the maintenance of a joint office and secretarial staff.

The difficulties here may be less apparent, but are none the less real; and may be properly considered under three heads:—

1. The Combined Fee.

The amount of this fee would depend on the status of the appointed executive officer, whether a full time medical man, part time medical man, with full time lay assistant, or part time medical man only.

Under any circumstances it would have to be collected by the College of Physicians and Surgeons, and would thereby become a compulsory levy on every member of the profession in Manitoba.

Under the least expensive method it would still have to approximate in amount to the present fees of the Manitoba Medical Association and College of Physicians and Surgeons added together, *i.e.*, Twelve Dollars or possibly slightly less.

To those who are already members of both organizations this would mean no increase in dues, but to those who are not members of the Manitoba Medical Association it would constitute a Five or Six fold increase; and would in effect mean compulsory membership in the Manitoba Medical Association.

It is at least doubtful if such a move, especially at the present time, would not in itself defeat the objective of an harmonious unified professional organization.

2. The Combined Secretary-Registrar.

There are certain very definite objections to the appointment of a full time medical man to such a position, which may be summarized as follows:—

It removes the occupant of such an office immediately from the practice of his profession and makes him dependent for his living on the continued tenure of the office. Insensibly as time progresses he must more and more lose touch with his profession and become more and more the office holder, subconsciously approaching each question from the viewpoint as to how it will affect the tenure of his office rather than as to how it will affect the professional well-being of his confrères.

It immediately makes the business and organization of the medical profession a one-man job. Instead of as at present, or as under other systems by which the work is largely done by Committees of actively interested, actually practicing members of the profession, it will become instinctive to let all decisions and all formulation of policy come from the one person, on the principle of "that being his job" and of "that is what he is paid for." That this would be an actual detrimental development must be apparent to all.

3. The Dual Control of a Secretary-Registrar.

Under the proposed system both bodies would continue to expect to give instructions to its appointed officer; and would continue to debate and decide on policies and activities with a very possible conflict in opinions arrived at, policies adopted, and instructions issued. This situation may easily develop even under an agreement as to the division of activities between the two organizations and would very quickly render untenable and unworkable the combined position. That this development is not imaginary or far-fetched may be illustrated by the fact that it has already developed in one province where a somewhat similar scheme is in operation.

3. The Allotment of Functions to the Respective Organizations.

The definite duties and privileges of the College of Physicians and Surgeons are laid down by the Medical Act as the issuance of licenses to practice to properly qualified graduates of medicine, and the power of discipline of its own members, with in addition certain more indefinite privileges in respect to the expending of money in any procedure that may be deemed for the welfare of the profession.

By some it is considered that the College should restrict its activities to its licensing and disciplining powers; and that all other matters should be dealt with by the Manitoba Medical Association.

The chief drawback to this arrangement is that the Association is under a handicap in dealing with Governments, Municipalities, Boards and other public bodies in that it is not a legally incorporated body, and in that it can not claim to speak for the whole medical profession of the Province.

This is a very real drawback to the satisfactory assumption of business activities by the Association.

4. The Allotment of All Business Activities to the College of Physicians and Surgeons.

Inasmuch as the College is the legally incorporated body of the profession and also inasmuch as its membership comprises the entire body of medical practitioners within the Province, it would appear natural and right that to this body should be entrusted the duty of conducting the business of the profession and of deciding the policy of such business activities.

Under present conditions, however, there are certain things that would require adjustment and alteration before such an allotment would be satisfactory to the general rank and file of the profession, and which would be necessary before such increased functions could be satisfactorily carried out and attended to. Among these may be instanced:—

1. Method of Election to the Council of the College.

The present method is such as may result occasionally in the return of a member not truly representative of the Division for which he is elected. A change whereby some method of nomination of candidates for election should be introduced would be more likely to ensure representation satisfactory to the general membership and also would be more likely to maintain the interest of the general membership in their representation on the Council.

2. Period of Service on the Council.

The present period of three years is too long to maintain active interest in the functioning of the Council by the membership of the College, and to ensure representation that shall be amenable to, and influenced by, the general desires and interests of the profession as a whole.

A change to a two-year period with if possible election of one-half of the membership each year, would result in keener interest by the profession and in a more flexible and readily influenced representation on the Council.

3. Meetings of the Council.

These have during the past not been sufficiently frequently held; and to conduct the increased business activities suggested, it would be necessary that meetings of the Council should be held once every three months, not only for the conducting of business, but also to control and direct the activities of the various sub-committees to whom the actual work of the various sections of business and organization would have been allotted, and from whom the Registrar as Executive Officer would take his instructions.

In view of the necessarily increased time and attention that would have to be devoted by members to the activities of the various committees it would be advisable that reasonable remuneration for time and expenses expended in the service of such committees, should be made probably on the same basis as is now made for attendance on Council meetings.

The Salary of the Registrar would also presumably have to be moderately increased in order adequately to recompense him for the increased time that it would be necessary to devote to the augmented duties of the position,

without, however, approaching even nearly to that of a full-time position, inasmuch as the work essentially would be in the hands of the various committees and also in order to avoid the unfavorable aspects of a full-time position previously enumerated.

It probably would be necessary if these changes were adopted to arrange for an increased revenue for the College. This might be arranged for possibly in part by a cancellation of the present life memberships of the College, and in part by an increase in the annual dues of the College members up to the present statutory limit of Five Dollars.

It is considered, however, that such an increase, if found necessary, might largely be compensated for by an accompanying reduction in the present fee of the Manitoba Medical Association to a nominal sum of Two Dollars, which might readily be done in view of the cessation of the business activities of the Association. If this were done it would mean an actual saving to those now members of both organizations and only a very moderate increase to those not now members of the Medical Association and would further be of assistance to the Association in the desired object of obtaining a One Hundred per cent. membership of the profession.

4. Publicity re. Council Activities.

The prevailing general feeling of the profession that they are not kept sufficiently informed of the activities of the Council should be met by the publication of the proceedings of the proposed more frequent meetings of the Council, preferably in the *Medical Bulletin*, the publication of which would presumably be taken over by the College of Physicians and Surgeons along with the other business activities.

If such, and possibly other changes that may be suggested, would be adopted by the College of Physicians and Surgeons, your Committee consider that this method of allotment of all business activities to that body would be the most satisfactory solution of the problem that has been placed before it; and we would therefore beg to recommend:—

THAT an agreement be entered into by the Council of the College of Physicians and Surgons on the one hand, and by the Executive Committee of the Manitoba Medical Association on the other, whereby

The Council of the College of Physicians and Surgeons agrees:—

TO undertake and maintain, as a privilege and duty, the conduct of all matters of business pertaining to the welfare of the body of the medical profession of the Province of Manitoba.

TO enact such changes in its by-laws or obtain such amendment to the Medical Act as may be necessary to provide for a method of election of its members by nomination, and to provide for a term of office of not more than two years with one-half of its membership to be elected annually.

TO hold meetings of the Council every three months and of its Committees as and when found necessary for the proper conduct of the business activities assumed.

TO undertake the publication of the monthly *Medical Bulletin* and to publish therein reports on the meetings of the Council.

TO hold at least one meeting each year open to the general membership of the College, at which all or any business enacted by the Council, or consideration of any matters of policy, or initiation of new business may be discussed and advised upon by the members of the College.

The Executive Committee of the Manitoba Medical Association agrees:—

TO continue to function as a voluntary organization devoted to the scientific and educational interests of the medical profession of the Province.

TO maintain its affiliations with the Canadian and British Medical Associations, and to continue its support of the District Medical Societies within the Province.

TO hold at least one Annual Meeting for the discussion and presentation of scientific subjects; at which meeting the election of officers and of such members of the Executive Committee as called for by the by-laws shall take place.

TO discontinue other business activities and the maintenance of a business office.

TO reduce its membership fee to such nominal sum as may be required for the conduct of its scientific activities only.

Medical Care for Citizens on Relief and State Medicine

THE negotiations which are being carried out by the medical profession with the authorities in attempting to fix the responsibility for medical services for *'relief cases'* have led to various comments from laymen. One of these is that the proposed system is a form of *'State Medicine'*.

The difficulty of estimating the value of this suggestion is increased by the fact that the meaning attached to the term *'State Medicine'* varies so widely that it is of little value as a term of reference. The principle that is being urged by the medical profession, namely that medical services for wards of the State should be provided by the State, is an old and quite well accepted one. The principle is merely being applied to deal with a temporary situation. The only way in which this could lead to a complete system of so-called *'State Medicine'* would be in case the whole population became wards of the State. Despite the fact that there are people who feel compelled to urge that such a condition would be desirable, it is not likely to develop.—C. W. MacC.

Minutes of Executive Meeting

MINUTES of a Meeting of the Executive of the Manitoba Medical Association, held in the Medical Arts Club Rooms on Friday, January 13th, 1933, at 6.45 p.m. Present:—

Dr. A. F. Menzies, *Chairman*	Dr. A. J. Douglas
Dr. F. W. Jackson	Dr. Ross Mitchell
Dr. W. H. Secord	Dr. G. D. Shortreed
Dr. D. C. Aikenhead	Dr. A. G. Meindl
Dr. C. A. MacKenzie	Dr. R. R. Swan
Dr. F. G. McGuinness	Dr. J. S. McInnes
Dr. G. S. Fahrni	Dr. W. H. Clark

Following dinner, the meeting was called to order by the Chairman, and minutes of the last meeting of the Executive, held October 11th, 1932, together with minutes of a special meeting of the Winnipeg members of the Executive, held November 21st, 1932, were read by the Secretary and adopted.

Medical Aids Limited.

Following discussion on this subject, it was moved by Dr. Ross Mitchell, seconded by Dr. F. G. McGuinness: That all correspondence with Mr. Cecil James in connection with this matter be turned over to the College of Physicians and Surgeons for their information and future observation. —Carried.

Mimeographing Annual Meeting Speakers' Papers.

Dr. Jackson reported that the cost of having this work done would be quite high. It would necessitate about 300 pages, and 600 copies of same could not be obtained for much under three hundred and fifty dollars ($350.00).

Extra Mural Post-Graduate Work.

Letter from Dr. T. C. Routley under date of October 7th, 1932, was read, advising that no further grant would be made towards this work for the year commencing October 1st, 1932, and that no negotiations with speakers be made until definite information was received from the Sun Life Assurance Company. Dr. Jackson advised that he had already been dealing with the Great West Life Assurance Company towards obtaining a grant for this work. Following discussion, it was decided that Dr. A. J. Douglas be appointed with Dr. Jackson, as a delegation of two from this Association, to interview the Great West Life Assurance Company.

Special Committee of the Winnipeg Medical Society re. Unemployment Relief.

Dr. Menzies gave a full report on the work done by this committee to date, advising that they had interviewed the Premier of the Province, and that a definite plan had been sent to him which he proposed to discuss at the forthcoming Ottawa Conference.

Medical Services to Single Unemployed Men.

Dr. Jackson advised that he and Dr. Douglas had been called to meet the Commission regarding single unemployed men placed on farms in rural Manitoba, and had been requested by the Commission to submit a memorandum of a definite scheme. Dr. Jackson read proposed scheme submitted, copy of which is on file. After this had been presented, the Commission informed them that they did not think action was necessary at the present time as there was not a great demand for medical services. However, Dr. Jackson reported two instances of accidents happening in the interim, where medical care was needed.

Interprovincial Relations Committee of the C.M.A.

Dr. Fahrni addressed the meeting and read communication received from Dr. J. S. McEachern, Calgary, a member of the Executive of the Canadian Medical Association and Chairman of the Interprovincial Relations Committee of the Canadian Medical Association. This letter stated that the grant from the Sun Life Assurance Company for post-graduate instruction tours would not be continued for the year, and suggested that the four Western provinces combined might contribute an amount of two thousand dollars ($2,000.00), the three Eastern provinces one thousand dollars ($1,000.00), and from these funds at least one tour could be arranged. It further stated that the two Central provinces for the time being could carry on this work within their own confines.

It was the opinion of the meeting that the Canadian Medical Association had ample reserves to at least assist in the financing of this work for another year, and it was moved by Dr. C. A. MacKenzie, seconded by Dr. R. R. Swan: That we first get in touch with the Western provinces before taking this up with the Canadian Medical Association, suggesting our views to them informally and giving them an idea of the situation. —Carried.

Dr. Fahrni in the meantime was asked to reply to Dr. McEachern's letter, and also to communicate with Dr. Routley.

Correspondence.

Letter from the British Columbia Medical Association under date of December 17th, 1932, was read, asking that official delegates be sent to their Annual Meeting.

Letter from the Ontario Medical Association under date of November 25th, 1932, was read, asking that an official delegate from this province attend their Annual Meeting to be held in Hamilton, May 30th to June 2nd, inclusive. Dr. Jackson stated that he might be going to Ottawa about that time, and would be pleased to attend the meeting in Hamilton if at all possible.

Dr. Fahrni stated that these letters should not be passed up lightly, and that it tended to create better feeling between the provinces and the profession generally if official visits were made by speakers from other provincial associations.

It was moved by Dr. C. A. MacKenzie, seconded by Dr. D. C. Aikenhead: That Drs. Ross Mitchell and G. S. Fahrni be a committee, in conjunction with the Secretary, to ascertain who might be willing to attend the above meetings. —Carried.

Further, it was moved by Dr. G. D. Shortreed, seconded by Dr. W. H. Secord: That these communications be acknowledged, informing them that action has been taken to comply as far as possible with their requests. —Carried.

Financial Statement.

In the absence of Dr. McGuinness, who had been called out, the Secretary read the financial statement for the year ending December 31st, 1932, which showed a deficit of $280.89. This statement was ordered to be audited and published in the usual way.

Field Secretary.

On presentation of this matter, Dr. Jackson retired from the meeting.

Letter from Dr. T. C. Routley under date of December 7th, 1932, was read by the Chairman, advising that the annual grant of $750.00 made by the Canadian Medical Association towards the salary of the Field Secretary would be discontinued as from December 31st, 1932. Discussion followed.

It was stated that the C.M.A. did not contribute to any other province for a like service, but it was believed that at one time they intended doing so, and having a Field Secretary to look after the C.M.A. work in each province.

Dr. Secord stated that, if some arrangements could be made to carry Dr. Jackson on for at least another eight or nine months, the question of amalgamation would be decided by that time, and he thought the Association should make a special effort to do this. The question of how much the Association could pay was discussed, as it was felt that Dr. Jackson was a very valuable man, and if possible his services should be retained until such time as other funds are available.

It was moved by Dr. Ross Mitchell, seconded by Dr. A. J. Douglas: That Drs. C. A. MacKenzie and F. G. McGuinness be a committee to ascertain an amount possible for the Association to pay, and to interview Dr. Jackson to see if his services can be retained. —Carried.

Sane Living. "Eat less and chew more; ride less and walk more; wear less and bathe more (applies to men only); work less and play more; talk less and think more; go less and sleep more; waste less and give more; scold less and laugh more; preach less and practice more,—and you will be better fathers, husbands and business men."—Nova Scotia Medical BULLETIN.

Medical Care for Citizens Receiving Government Relief Funds

PROGRESS OF NEGOTIATIONS WITH THE AUTHORITIES

AS reported in the December number of the *Bulletin*, the Committee representing the Winnipeg Medical Society and the Manitoba Medical Association have been negotiating with the authorities with regard to the question of medical care for citizens who are receiving relief funds. They have attempted to convince the governing bodies that medical care is as much a necessity of life as food, clothing and shelter, and therefore that, when the state assumes responsibility for finding food, clothing and shelter for a citizen, it should also provide for medical services.

The people who are administering relief funds and the municipal and provincial authorities passed the final responsibility for dealing with the question on to the Dominion Government.

The first attempt to bring the matter to the attention of the Dominion Government was made by the Executive Committee in interviewing the Hon. Mr. T. G. Murphy on December 20th. The Minister of the Interior promised that the question would be placed before the Prime Minister, the Minister of Pensions and Public Health, and the Minister of Labour. The Hon. Mr. Murphy was apparently of the opinion that the care of the people on relief was only a small fraction of the work done by medical men. He asked if this was too large a contribution to ask the profession to make to the country during this period of depression. He further suggested that it was inconsistent to suggest that the municipalities and the Provincial Government were not in a position to assume the financial responsibility for these medical services and yet to suggest that therefore the Dominion Government must do so: the Dominion Government also had its financial difficulties.

On January 12th the committee interviewed the Premier of Manitoba, the Hon. Mr. John Bracken, and also the Hon. Mr. R. A. Hoey, Minister of Education and Health and Public Welfare. The Premier pointed out that, if the province assumed responsibility for providing medical services for citizens in receipt of relief funds, it would merely add another item to the already overstrained financial resources of the province. He admitted, however, that this did not absolve the government of responsibility in the matter. The acceptance of this principle is of fundamental importance, yet it is rendered of little more than academic interest when coupled with the advice that the financial position of the province makes it impossible for the government to put the principle into action. The Premier asked if the committee had a definite plan to offer. The chairman pointed out that all the profession was attempting to do at present was to have the authorities accept the principle that they, the authorities, and not the medical profession were responsible for providing medical services for citizens receiving government relief funds. He assured the Premier that, if this principle were accepted, the profession would quite promptly furnish a scheme for the care of these people.

The Premier offered to take up the question with the Dominion Government at the Dominion-Provincial Conference at Ottawa. He also agreed to have a committee of the house appointed to co-operate with the profession in dealing with the problem.

Before approaching the Dominion Government, the Hon. Mr. Bracken asked that the medical societies give him a plan which they considered would take care of the situation. The Committee, therefore, after due consideration, decided to propose a scheme which in essentials corresponds with that which was worked out by the medical profession in Saskatchewan. The outline of the proposed system is as follows:—

1. The Medical Profession of Manitoba believes that responsibility for medical relief rests with the municipality. If the municipality is unable to supply relief, the province must assume the obligation. Failing this, the province and not the doctors should request Federal aid.

2. Payment to be made on a 50% basis of the accepted schedule. It is understood and agreed that this shall not be construed as having any effect on the schedule of fees as it applies generally, or that it shall form any precedent for any general schedule of fees, which may in future be applied to individuals, or the municipality, or the state.

3. **Indigents**: Where the indigency of the patient is in dispute, a local arbitration board shall be given the necessary authority to arrange an amicable settlement, the personnel of the board to consist of the attending physician, the Reeve or other elected member of the Council, and a third party, preferably a resident of the community, to be selected by the two above-named members.

4. **Accounts**: All accounts for the medical treatment of indigents to be submitted to the municipality.

5. Medical treatment shall be deemed to include medical, surgical and obstetrical treatment.

6. As regards cities, these conditions shall apply to those registered on relief with the Relief Commissions.

7. In cases where the city or municipality finds itself unable to pay for such services out of its own resources, it shall be the duty of the city or municipality to make the necessary arrangements with the Government or the Relief Commission, or otherwise, for the advancement of a sufficient sum of money to take care of the payments herein referred to. And further, that it shall not be the duty of the doctor to assume any obligation in that regard.

The medical associations of the other three Western provinces also approached their respective Premiers and arranged for them to present the problem at the Dominion-Provincial Conference at Ottawa. The Secretary of the Canadian Medical Association was able to arrange for the Ontario Premier to present the case at the Conference as well.

The result of the negotiations at Ottawa have not been officially reported, but the press of January 20th carried a news item which recorded the results of the conference. It was stated that, with regard to medical services, "In the opinion of the committee a limited expenditure for medical attention, where circumstances render such expenditure necessary, might be regarded as coming within the scope of the definition of direct relief."

The negotiations of the committee up to the present have accomplished two things. They have received from the Provincial Government the admission that the authorities and not the medical profession should pay for the expense of providing medical services for citizens receiving government relief funds. They have also been successful in having the Provincial Government accept the responsibility for asking aid from the Dominion Government. This, of course, is a natural consequence of the previous principle.

The negotiations have not been brought to a final conclusion. What action will ultimately be taken remains to be seen. In the meantime, of course, the medical profession will, as usual, try to carry on.—C. W. MacC.

News Items

— of —

Department of Health and Public Welfare

The following is an article published in the *Health Examiner* and written by Dr. M. Harwich, which we thought would be of interest to the practicing medical profession:—

HEALTH EXAMINATION FROM THE GENERAL PRACTITIONER'S VIEWPOINT

THERE has been a great deal of propaganda in the last few years directed toward interesting the general practitioner in periodic health examination, and for this purpose there have been published articles, pamphlets, journals and even moving pictures have been produced and exhibited. An intensive campaign has been directed to the public in order to sell the idea, since it is a comparatively new one, and as one official of the Life Extension Institute said, "It is one of the hardest propositions to sell the public the idea of going to a doctor when in perfect health."

The concept of a periodic health examination is a very laudable one. But how is the general practitioner going to fit into the picture from a practical standpoint, and by this I mean as regards the cost of the service to the patient and to the physician.

The physician must first interest his patient in the idea, and this he will probably do by mailing frequent letters, and by preaching it on every possible occasion. If the patient does not attribute ulterior motives for gain to the doctor's efforts, and finally does come to the office for a health examination, he expects to and does undergo a complete physical examination, which to be thorough must be painstaking and time consuming, and will include a blood and urine examination, a fluoroscopy and possibly a chest plate or gastrointestinal examination. An examination of this type, together with the advice that goes with it, will consume on an average from three-quarters to one hour per patient, if not longer, and this will necessitate limiting the number of patients seen per day. (That is, if the practitioner sees them).

What does the patient expect to pay the general practitioner for this service? At the most, from what I have seen, the average patient expects to pay the ordinary office fee of two or three dollars, and if he has to pay five, does so under protest and begins to suspect the doctor of profiteering. I am speaking of the general practitioner, mind you, and not the specialist.

The question of the cost of the service to the physician becomes an interesting one — the cost of maintenance of his office and equipment, time consumed on a complete examination with advice, blood, urine and fluorscope examination, and the cost of taking and developing an x-ray film. Here we have the question of the cost of installing the fluorscope and x-ray equipment, with its upkeep and depreciation. I won't go into figures, but will leave that to the imagination of the reader.

Can a general practitioner go into this work at the prices offered? Obviously he cannot — at least from a business standpoint, though idealistic doctors are supposed to forget such things as business in this world of rents, gas, electric and telephone bills, nurses' salaries, cost of equipment, etc. Therefore, some method of mass examination must be conceived, where the cost will attract the patient and also lower the cost of the service to the physician.

This can only be done by several physicians combining in a group, where the plant and equipment are jointly owned, the work subdivided, each man doing a special part and the whole coördinated by one of the group, or in consultation with the rest of the group. A typewritten report with advice is then given the patient. As a part of its plan, such a group would necessarily have to maintain a publicity and promotional department.

An example of this is the Life Extension Institute, a lay managed commercial organization. But what does this lead to? The springing up of groups, bidding and advertising for this business either overtly or covertly, and the elimination of the general practitioner from the field.

Another example of a group which can bring low cost to the patient is the benevolent type, namely, the clinic or centre. Some of our clinics or centres are entering or plan to enter this field. It is easy for them with their beautiful tax-free buildings, with their splendid equipment, both donated and maintained by philanthropic funds, with their physicians contributing their services without recompense, and with their untrammeled publicity, to outcompete the general practitioner with his small office, lack of atmosphere and inadequate equipment.

This does not mean that the general practitioner is incapable of conducting health examinations. In fact, he is the logical person to perform them, because of his intimate contact with the patient, his knowledge of the patient's mental, physical and constitutional makeup, and his family background. But the question is one of bridging the gap of mutual expense. Perhaps one solution is the delegation of all laboratory and radiographic work to a coöperative laboratory managed and owned by physicians, where this work can be done at a lower cost; or the opening of the x-ray and laboratory facilities of the clinical centres to the general practitioner at a reasonable or low cost to the patient. This would leave the clinical and mental examination and appraisal to the family practitioner, where it belongs.

It seems to me that only in this way can both the general practitioner and the patient benefit by all this propaganda for periodic health examination, and only in this way can the family doctor fit into the scheme of things. And if this brief paper will have stimulated discussion on the practical phases of this subject, then it will have accomplished its object.

* * * * *

In the above, Dr. Harwich raises a number of pertinent questions: *First*, how can the private practitioner secure a clientele for the practice of preventive medicine and the health examination? Quite appropriately, Dr. Harwich points out that the physician must interest his patients in this form of practice by preaching it on every possible occasion. It is apparent that the *best possible occasion* is when the patient comes to the physician's office with an acute illness. The physician can with complete propriety and with evident pertinence say to his patient: "When you have recovered from this illness, I want you to come back, so that I might examine you from head to foot and see whether you are in good condition. I want to see if it is possible to prevent a recurrence of this illness and to stave off any other sickness." The physician might go further and explain to his patient that in addition to making a more thorough physical examination than either time or the patient's condition allows, it were desirable for him to inquire into the living habits of the patient, to determine whether therein might not lie the cause of some of his defects.

The physician might go even further and not leave it to the patient to return, *if and when* he thinks of it, but rather set a date there and then for the patient's return. When such a date is set, it is incumbent upon the

physician or his secretary to communicate with the patient a few days in advance, to remind him of his engagement. It is incumbent upon the physician to so present the matter to his patients that they will understand the value of the services offered by him.

Assuming that the patient has returned for a health examination, what does he expect and what type of service will he receive? In the minds of many physicians the laboratory phase of the health examination stands out most prominently. They seem to take it for granted that every patient requires an extensive amount of laboratory work, including a Wassermann, urinalysis, blood chemistry, fluoroscopic and x-ray examinations, etc., etc. This impression is essentially erroneous. In their everyday dealing with sick patients, physicians do not find it essential to have much laboratory work done on each and every patient. There ought to be no occasion for any more laboratory work in dealing with well patients than there is when dealing with sick patients. The basic so-called laboratory tests in the routine health examination include only hemoglobin determination and urinalysis. The Wassermann test or its equivalent is desirable; some even consider it essential. But it is not in the opinion of many an absolute requirement in the health examination.

The physical examination of the patient in the health examination is made in a routine and thorough fashion, the physician employing the ordinary instruments of his office. The examination card adopted by the Greater New York Committee on Health Examination indicates the scope and routine of the examination.

However, the most important part of the health examination lies in the review of the patient's living habits and in a study of the so-called personal hygiene and environmental factors. It is these that make the health examination different from the physical examination, and unique as far as the patient is concerned. The physician should spend the major portion of his time inquiring into the ordinary and intimate details of the patient's life. He should carefully scrutinize his dietetic habits and his habits in work, rest and recreation. Where he finds these faulty, he should take time to advise his patient on what corrections are required. He should not only instruct his patient on what to do and what to avoid, but also the reasons therefor. In other words, he should advise and teach his patient the art of living. It is superfluous to observe that the mental hygiene aspect of medical practice enters prominently into this service. This phase of health examination cannot be too strongly emphasized. Without it the health examination remains merely a physical examination.

Should the routine health examination indicate the need for further laboratory or other procedures, the patient should be informed of this and a proposal for further examinations should be made to him. This is the routine which is followed in ordinary so-called curative medical practice. If the patient agrees to submit to further examinations, he will readily appreciate his obligation to pay for the additional work. He usually does so when he is acutely ill. The lack of urgency in the situation presented by the health examination, may call for some exposition on the part of the physician on why the additional examinations are required.

However, with the vast majority of patients, the routine health examination will suffice, and even where the patient requires additional laboratory work which he cannot afford, careful following of the patient and subsequent examinations will many a time give the physician further knowledge of the patient's condition, and in many instances make the desired laboratory work unnecessary.

Dr. Harwich apparently urges the desirability of conducting health examinations by a group of practitioners. His opinion is shared by many others. However, we are of the opinion that in the vast majority of instances contact of the patient with one, and that one his or her own physician, is the more preferable. The idea of a coöperative laboratory which Dr. Harwich sponsors is indeed a good one.

It has also been pointed out many a time before that the private practitioner can undertake to establish a practice of health examinations outside of his regular office hours. He can use his inactive hours for this purpose. By conducting his health examinations at such hours, he could allow himself sufficient time to deal with each patient thoroughly, and he could also augment his income and proportionately reduce his overhead costs. Viewed in this way, the practice of health examinations does not involve the additional expenditure of money, nor the purchase of expensive equipment, nor the running of a health examination practice at an excessive cost to the doctor and the patient.

* * * * *

NOTICE!

Our attention has been drawn by unmarried mothers, who call at the Vital Statistics Division of this Department, that they originally have given false information as to their names, etc.

Questioned as to the reason for so doing, they sometimes state that they have been advised to do so by their own physician, and were given to understand that the records kept in the Division of Vital Statistics were public property and that their particular registration would not be safeguarded.

We would like to take this opportunity of informing the Profession that facts in reference to births, marriages and deaths are not made public, and every precaution is taken by the Department of Health and Public Welfare to safeguard any information which may be given. The public as a group, and curiosity-seekers are not allowed access to the records.

In view of the fact that many of these children are adopted and that adopting parents are naturally anxious to have birth registration in their own name, it is necessary that accurate information be given in the first instance, otherwise the adopting parents find it next to impossible to get a proper registration made, and an injustice is thereby caused both to the child and to the adopting parents.

We feel confident we may rely on the co-operation of every practicing physician to do his part in seeing that accurate information is given at the time of the original registration of birth.

* * * * *

COMMUNICABLE DISEASES REPORTED
Urban and Rural : December, 1932

Occurring in the Municipalities of:—

Chickenpox: TOTAL 275—(late reported November cases: Binscarth 2, Neepawa 2, Shoal Lake V. 1, Westbourne 1, Treaty Indians 4), Winnipeg 167, St. Boniface 15, Deloraine 10, Dufferin 9, Westbourne 9, Kildonan East 8, McDonald 6, St. James 6, Miniota 5, Gladstone 3, Hillsburg 3, Neepawa 3, St. Vital 3, Brandon 2, Carman 2, Minnedosa 2, Tache 2, Whitehead 2, Boulton 1, Gilbert Plains R. 1, Grandview T. 1, Hamiota 1, Kildonan North 1, Kildonan West 1, Rapid City 1, Unorganized 1.

Whooping Cough: TOTAL 135—Winnipeg 114, St. Boniface 9, Kildonan W. 8, St. Vital 2, St. James 1, Portage R. 1.

Scarlet Fever: TOTAL 104—(late reported November cases: Unorganized 13, Armstrong 1), Winnipeg 23, Roland 10, Eriksdale 9, St. Boniface 8, McDonald 7,

Portage R. 6, Portage C. 5, Lac du Bonnet 3, Morris R. 3, Selkirk 2, St. James 2, Assiniboia 2, Bifrost 2, Birtle R. 1, Brandon 1, Plum Coulee 1, Rockwood 1, Ste. Anne 1, Transcona 1, Strathcona 1, Ste. Rose R. 1.

Mumps: TOTAL 69—Winnipeg 64, Eriksdale 3, Kildonan E. 1, St. James 1.

Tuberculosis: TOTAL 45 — Winnipeg 10, Treaty Indians 12, Unorganized 3, Arthur 2, Brokenhead 1, Coldwell 1, Gimli R. 2, Hanover 1, Pipestone 1, Portage C. 1, Ritchot 1, Rockwood 1, Rosedale 1, Selkirk 1, Stanley 1, Swan River T. 1, St. Boniface 1, St. Francois Xavier 1, St. Vital 1, The Pas 1, Transcona 1.

Diphtheria: TOTAL 29—Winnipeg 11, Unorganized 8, St. Boniface 2, Assiniboia 1, Kildonan E. 1, Lawrence 1, North Norfolk 1, Siglunes 1, Stanley 1, Stonewall 1, Strathclair 1.

Typhoid Fever: TOTAL 11—(late reported October case: Swan River T. 1), Shellmouth 3, Boulton 2, Daly 1, Hanover 1, Rosedale 1, Souris 1, Winnipeg 1.

Measles: TOTAL 9—Harrison 3, Winnipeg 3, Eriksdale 1, Minnedosa 1, St. Boniface 1.

Erysipelas: TOTAL 8—Winnipeg 3, St. Boniface 2, Brandon 1, Portage City 1, Strathclair 1.

Trachoma: TOTAL 6—Rhineland 3, Emerson 2, Morris R. 1.

Septic Sore Throat: TOTAL 6—Brandon 6.

Influenza: TOTAL 2—Argyle 1, Winnipeg 1.

Puerperal Fever: TOTAL 2—Grandview R. 1, Winnipeg 1.

Lethargic Encephalitis: TOTAL 1—Carman T. 1.

German Measles: TOTAL 1—Brandon 1.

* * * * *

DEATHS FROM ALL CAUSES IN MANITOBA
for Month of November, 1932

URBAN—Cancer 49, Congenital 17, Pneumonia 10, Tuberculosis 8, Puerperal 3, Diphtheria 1, Typhoid Fever 1, all other causes 116, Stillbirths 16.—TOTAL 221.

RURAL—Congenital 29, Cancer 17, Pneumonia 16, Tuberculosis 15, Puerperal 4, Diphtheria 2, Influenza 1, Measles 1, Lethargic Encephalitis 1, all other causes 101, Stillbirths 9.—TOTAL 196.

INDIANS—Tuberculosis 10, Pneumonia 1, all other causes 3.—TOTAL 14.

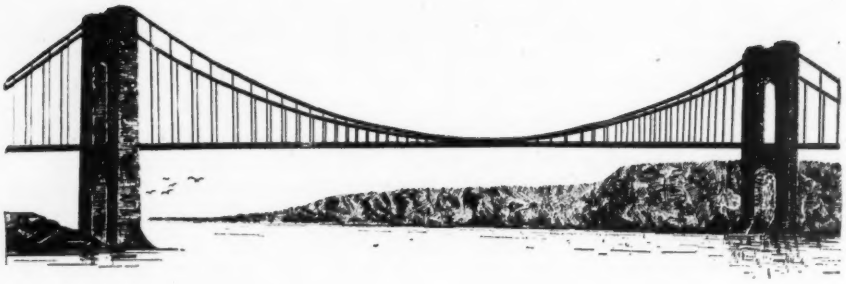
GRAND TOTAL..... 431 for the month of November, 1932.

Western Canada Medical History

by Ross MITCHELL

WINNIPEG'S FIRST MURDER TRIAL

IN 1872 Winnipeg was a hamlet but, even at that time, incorporation was being considered, and, indeed, was effected the next year. The community had hardly recovered from the disturbances brought about by the setting up of Riel's provisional government, the execution of Thomas Scott and the arrival of the Expeditionary force under Colonel Wolseley in August, 1870. To maintain order in the district a battalion of Canadian troops which had come with Wolseley's force remained stationed at Fort Garry. One of these soldiers, Leon Dupont, withdrew from the battalion and became patrolman on the small Winnipeg police force. Another soldier, Frederick Voght, was considering a similar step. On the evening of December 6th, 1872, Dupont paid a visit between 6.00 and 6.30 p.m. to No. 1 Barrack room situated within Fort Garry to see Voght and to discuss with him his plans for joining the police force. Voght, Dupont and a third man, Private Goyer, were sitting side by side on Goyer's bed. They were chatting in apparently amicable fashion when Dupont asked Voght if he were afraid of balls, and, on Voght



Bridging the Crisis

IN all the Pneumonias, when the vitality is low and the heart is weak, the application of an Antiphlogistine jacket is often the bridge which will ease the discomfort and so enable the patient to pass the crisis and to reach safely the point of resolution.

Not only is there a prompt assuaging of the pain, but dyspnœa is relieved, the action of the heart improved and a general soothing of the patient with induction of sleep follows, as the result of the relaxant effects which an Antiphlogistine dressing affords.

Its application is simple and because it retains its potency for 24 hours, it requires no unnecessary disturbing handling of the patient.

℞ **ANTIPHLOGISTINE**

for Pneumonia

Antiphlogistine is made in Canada.

THE DENVER CHEMICAL MFG. CO.
153 Lauchetiere St., W. Montreal

answering "No," Dupont pulled out a small revolver, levelled it at Voght's head and pulled the trigger. Voght fell across the bed with a wound in the right temple and died almost immediately. A corporal, who was present, placed Dupont under arrest and summoned the Adjutant of the battalion. Dr. Codd was also called, but when he arrived, Voght was beyond help.

On the evening of the following day a coroner's inquest was held at which Dr. Curtis James Bird presided. After several privates and the corporal had given evidence, the Adjutant of the battalion stated that Dupont had said to him that he had not intended to shoot Voght and that he did not know the revolver was loaded. Other evidence, however, showed that Dupont had bought a revolver similar to that produced at the inquest on the night before the shooting, and a sergeant of the battalion testified that there had been bad feeling between Dupont and Voght the previous summer. Dr. Alfred Codd, who was the battalion medical officer, testified as to the location of the wound and stated that the man was dead when he was summoned.

Dupont was tried on a charge of murder on January 17th, 1873, but was convicted only of common assault, and received a sentence of six months in the Jail at Lower Fort Garry. Poor Voght was buried on December 8th, 1872, in what the *Free Press*, then issued only weekly, described as "very inclement weather." A full military funeral was held from Fort Garry to St. John's cemetery.

Dr. Bird, the Coroner, was a son of James Curtis Bird, a Chief Factor of the Hudson's Bay Company. He was born in the Red River Settlement, took his medical degree from Guy's Hospital, London, and returned to practice first in what is now Middlechurch and later in Winnipeg. On the death of Dr. John Bunn, in 1861, he became coroner and held that position till his death. He operated a fine drug store, and in 1882 built the Bird Block which stands at the south-east corner of Main and Bannatyne, where he had his office and residence. He died in 1876 while on a visit in London, England.

Dr. Alfred Codd came west with the Ontario Rifles in 1870, was a military surgeon for a number of years both at Fort Garry and at Fort Osborne Barracks, and also enjoyed a large civilian practice.

History of Medicine in Canada

SMALLPOX AMONG THE INDIANS

by W. A. Gardner

SMALLPOX appeared first in the West Indies in 1507. In 1520 Spanish troops brought smallpox into Mexico where it is said three and one half million Indians died of this disease. In Bradford's History of Plymouth Plantation he describes an epidemic of Smallpox amongst the Indians. "There was a company of people up above the river Conigtecut, about a thousand of them had inclosed themselves in a forte which they had strongly palissadoed about. Three or four Dutchmen went up to get their trade and prevent them for bringing it to the English. It pleased God to visite these Indeans with great sickness and such a mortalitie that of a thousand, above nine hundred and a halfe of them dyed, and many of them did rott above ground for want of buriall, and the Dutch were almost starved before they could get away for ise and snow."

"This spring also, those Indeans that lived aboute their trading house fell sick of the Smallpoxe and dyed most miserably. As they lie on their hard matts, the poxe breaking and mattering their skin cleaving to the matts they lye on; when they turne them a whole side will flea of at once and they will be all of a gore blood, most fearful to behold; and then being very sore, what with coulde and other distempers, they dyed like rotten sheep."

From 1627 to 1663 Canada was governed by "The one hundred Associates," a company Cardinal Richelieu formed. During this period the Jesuits kept their records known as the "Jesuit Relations." They established a mission amongst the Hurons near Georgian Bay and the following year Smallpox brought from the lower St. Lawrence decimated them.

"Everywhere was heard the wail of the sick and dying children." The Hurons live in the midst of their sick. The evil spread from house to house, from village to village and finally throughout the country.

They blamed the priests for spreading the disease and decided the only way to get rid of it was to massacre the French. Though the missionaries were frequently threatened they were not slain. Father Ragneneau wrote "A young man forcibly seized the crucifix about my neck and says that I should die. He lifts the hatchet directly above the middle of my head now uncovered and deals his blow so steadily that Father Chaumonot and I think to see at that moment what we have so long desired (martyrdom).

"I know not what stopped the blow unless the greatness of my sins, but short of feeling the hatchet cleave the head one cannot see oneself closer to death."

In the Relation of 1640, in the account of the suffering and hardship of the missionaries among the Indians we note that:—"The Hurons were decimated by small pox and the Iroquois. The Iroquois purchased firearms from the Dutch at Albany on the Hudson, and with these firearms they began a war of extermination against the Hurons so that by 1650 the Hurons as a tribe had ceased to exist."

Smallpox, war and alcohol reduced the Iroquois by 1680 to only a weak resemblance of the warlike nation that had wiped out so many other tribes. "In September 1671 Father Albanel halted a few days among the Kakauchue who dwelt on Lake St. John, on his way to Hudson Bay. He says, "The inhabitants have been greatly diminished in numbers by wars with the Iroquois, and by the smallpox.' Father Albanel reached James Bay the next year and took possession of that region for France."

The following is a narrative on exploring the neighborhood of Lake Superior:—"A still greater expense arose from the presents I had to give to cause the savages to come to Montreal, who had been diverted by the Abenakis to the English and Dutch, who made them believe the pestilence was in the settlements of the French and that it had gone up as far as Nipissingine where the greater part of the Nipissiriniens had died of it."

English and French in their rivalry for the fur trade supplied the Indians freely with brandy. Monseigneur de Laval, Bishop of Quebec, put a ban on brandy and ruined the fur trade to the French.

"The English traders untrammelled by clergymen had no scruples in continuing the traffic, in fact Benjamin Franklin said he believed "rum was created by the Almighty to kill off the Indians and bring the land into the possession of the white race."

The Indians traded at Orange (Albany) and Manatte (Manhatten). LaSalle explored the Mississippi in 1682 and took possession of that vast

country for France thus controlling the two vast rivers and hemming in the English who were very jealous of these French possessions. The Omahas, Osages and Kansas dwelling along the Wabash and Ohio rivers, suffered severely from Smallpox.

The Indian population was never very large. The Algonquins, fifty thousand in number, ranged from Kentucky to Hudson Bay. It is supposed there were two hundred thousand Indians in Canada. In the upper lake region the Ottawas suffered severely from Smallpox. The Hurons numbered sixteen thousand and dwelt between Lake Simcoe and Georgian Bay. Along the shores of Lake Superior were the Ojibways and in the Western Plains the Crees and Blackfeet. The Arthapaseans dwelt along the Mackenzie and extended to Alaska.

Father Charlevoix, who went down the Mississippi in 1720, found the Indians ravaged by Smallpox. "Their burying place appeared like a forest of poles and posts newly set up." In 1733 smallpox appeared in the Canadian Northwest amongst the Piegans who caught it from the Snake Indians as related to Thompson by a Piegan. "Next morning at the dawn of day we attacked and with our sharp daggers and knives cut through the tents, but our war whoop stopt instantly; there was no one to fight with but the dead and dying each a mass of corruption. We thought the bad spirit had made himself master and destroyed them. We took the best tents and some plunder and the second day after, this dreadful disease broke out and spread as if carried by the bad Spirit. We no longer moved about with the song and the dance but with tears, shrieks and howlings of despair."

Smallpox broke out among the Monsoni, Crees and Assiniboines in 1738 when they were attacking the Sioux and paralyzed their movements and ended their desires for war. The worst epidemic of Smallpox was in the years 1755 and 1757. Almost every house was visited. It spread west to Montreal and Niagara and south through New England. It destroyed great numbers of English, French and Indians.

In 1781 smallpox raged amongst the Indians at Hudson's Bay where three-fifths of them died and the same death rate prevailed amongst the Chipaways, the forest Indians, and the Sieux, the Plains Indians by whom it was carried over the Plains and over the Rocky Mountains. In 1783 eleven hundred died in Quebec city alone.

"In the year 1802 the Omahas who were once the most numerous and powerful race of the prairies were practically exterminated by smallpox and today exist only as a tradition."

The Five Nations Indians assembled at Fort George in Ontario in 1807 in appreciation of vaccination wrote to Edwar Jenner:—

"Brother, Our Father has delivered to us the book you sent to instruct us how to use the discovery which the great spirit made to you, whereby the smallpox, that fatal enemy of our tribe, may be driven from the earth. We shall not fail to teach our children to speak the name of Jenner and to thank the Great Spirit for the bestowing upon him so much wisdom and so much benevolence. We send with this a belt and string of Wampum in token of our acceptance of your precious gift, and we beseech the Great Spirit to take care of you in this world, and in the land of spirits."

On the fly leaf of the book Dr. Jenner wrote:—

For the Chief of the Five Nations, from Dr. Jenner, London

11th August, 1807.

The title page of the book:

ADDRESS
OF THE
ROYAL JENNERIAN SOCIETY
FOR THE
EXTERMINATION OF THE SMALL-POX
WITH THE
PLAN, REGULATIONS
AND
INSTRUCTIONS FOR VACCINE, INOCULATION
TO WHICH IS ADDED
A LIST OF SUBSCRIBERS
INSTITUTED IN 1803.

"Thou shalt not be afraid for the pestilence that walketh in darkness, nor for the destruction that wasteth at noonday."
—Psalm xci, verses 5 and 6.

University of Manitoba Medical Library

LIST OF RECENT ACCESSIONS TO THE LIBRARY
Session 1932-33

Abbott, Maude.—History of medicine in the province of Quebec. Toronto, Macmillan co., 1931. Gift.

American Otological Society.—Transactions; 1931, v. 21. Gift.

American Otological Society.—Index to Transactions, vs. 1-18; 1872-1928. New Bedford. Gift.

Ball & Evans.—Diseases of the kidney. London, Churchill, 1932.

Bourque, N. O.—The thyroid gland and its diseases. Privately printed, 1927. Gift.

Boyd, Wm.—A text book of pathology. Phila., Lea & Febiger, 1932.

Boys, W. F. A.—A practical treatise on the office and duties of Coroners in Ontario and other provinces . . . & . . . Newfoundland; 4th ed. Toronto, The Carswell co. Ltd., 1905. Gift.

British Pharmacopœia, 1932.—London, Constable, 1932.

Bumpus, H. C.—Minor surgery of the urinary tract. Phila., Saunders, 1932.

Burton, Robert, 1577-1640. The anatomy of melancholy. Reprinted from 3rd ed. for H. Cripps, 1628. New York, Empire State Book co., 1924. Gift.

Camac, C. N. B.—Imhotep to Harvey; backgrounds of medical history. New York, Paul B. Hoeber Inc., 1931.

Cameron, A. T.—Text book of biochemistry; 3rd ed. London, Constable, 1931.

Canada; Laws-Statutes.—Criminal code and other selected statutes of Canada, 1928. Ottawa, Acland, 1928. Gift.

Canadian Medical Association.—The book of Canada . . . on the occasion of the meeting of the British Medical Association in Winnipeg, August, 1930. Toronto, Canadian Medical Association, 1930. Gift.

Clark, A. J.—Applied pharmacology; 4th ed. London, Churchill, 1932.

Clement, G.—Thou shalt not kill. A doctor's brief for the unborn child. Authorized trans. from the French; 4th ed. Phila., Peter Reilly co., 1930. Gift.

Drouet et Hamel.— . . . L'Hérédo — syphilis mentale. Paris, Masson, 1930. Gift.

Duke-Elder, W. S.—Text book of ophthalmology; v. 1. The development, form and function of the visual apparatus, London, Kimpton, 1932.

Eason, J.—Exophthalmic goitre. Edinburgh, Oliver & Boyd, 1927.

Edinburgh Obstetrical Society.—Transactions; Sessions 70-75, 1908-1921. Gift.

Feldman, W. H.—Neoplasms of domesticated animals. Phila., Saunders, 1932.

Fried, B. M.—Primary carcinoma of the lung; bronchiogenic cancer; A clinical and pathological study. Baltimore, Williams & Wilkins, 1932. Gift.

Goodall, J. R.—Puerperal infection. Montreal, Murray Printing co., Ltd., 1932. Gift.

Gorgas memorial institute of tropical and preventative medicine, inc., Gorgas memorial laboratory; Research work touching causes and prevention of tropical diseases . . . Panama. Washington, U.S. Gov't., 1928. Gift.

Hadfield & Garrod.—Recent advances in pathology. London, Churchill, 1932.

Harrison, G.A.—Chemical methods in clinical medicine; their application and interpretation with the technique of the simple tests. London, Churchill, 1930.

Hawthorne, C. O.—Short essays on medical topics. London, Bale Sons & Danielsson, 1928. Gift.

Henry Phipps Institute, Phila.—Annual report, 1931, v. 23. Gift.

Institut Pasteur, Paris.—Vaccination preventive de la Tuberculose de l'homme et des animaux par le BCG. Rapports et documents . . . en 1932. Paris, Masson, 1932. Gift.

Johns Hopkins Hospital, Baltimore.—Wilmer Ophthalmological Institute. Collected reprints from the Wilmer Ophthalmological Institute of the Johns Hopkins University and Hospital; v. 2, 1930-31.

Joll, C. A.—Diseases of the thyroid gland with special reference to thyrotoxicosis. London, Heinemann, 1932.

Jordan, H. E.—Text book of histology; 5th ed. New York, Appleton, 1930.

Kennedy, J. W.—Practical surgery of the Joseph Price hospital. Phila., F. A. Davis co., 1928. Gift.

MacNevin & Vaughan.—Mouth infections and their relations to systemic diseases; v. 1. New York, Joseph Purcell Research Memorial, 1930. Gift.

Man, E. H.—On the aboriginal inhabitants of the Andaman Islands; with a report or researches into the language of the South Andaman Island, by A. J. Ellis. Reprinted from the Royal Anthropological Institute of Great Britain & Ireland - Journal, 1885. London, 1932. Gift.

Montague, J. F.—Psyllium seed; the latest laxative; a scientific treatise. New York, Montague hospital, 1932. Gift.

Muir & Ritchie.—Manual of bacteriology, rev. by C. H. Browning & T. J. Mackie; 9th ed. London, Humphrey Milford, 1932.

Osgood & Allison.—Fundamentals of orthopedic surgery in general medicine and surgery (Harvard Lectures). New York, Macmillan, 1931.

Price, F. W.—Diseases of the heart; 2d ed. London, Oxford University Press, 1927.

Randall, W. R.—The college library; based on a two year study of two hundred college libraries. Chicago, American Library Assoc., 1932.

Rawling, L. B.—Stepping stones to surgery. London, Lewis, 1930.

Robert Dawson Evans memorial for clinical research & preventative medicine, Boston. Collected publications No. 1. Endocrine studies. Boston, The Trustees, 1929. Gift.

Rudolf, R. D.—Notes on the medical treatment of disease; 3rd ed. Toronto, University of Toronto, 1930.

Sollmann, T.—A manual of pharmacology; 4th ed. Phila., Saunders, 1932.

Stimson, P. M.—Manual of the common contagious diseases. Phila., Lea & Febiger, 1931.

Stout, A. P.—Human cancer, Phila., Lea & Febiger, 1932.

United Fruit co., Medical department.—Annual report; v. 20, 1931. New York, United Fruit co., 1931. Gift.

Williams, E. H.—The doctor in court. Baltimore, Williams & Wilkins, 1930.

Wood, C. A. comp. & ed.—An introduction to the literature of vertebrate zoology. (McGill University publications, Ser. 11, No. 24). London, Oxford University Press, 1931. Gift.

New Periodical Subscriptions

Annals of Internal Medicine.—Phila., American College of Physicians.

Australian & New Zealand Journal of Surgery.—Sydney, Australasian Medical Publishing co.

League of Nations.—Quarterly bulletin of the health organization. London, Allen & Unwin.

Clinical Meetings

At Brandon General Hospital—
2nd Wednesday at 12.30 p.m.

At Brandon Hospital for Mental Diseases—
Last Thursday. Supper at 6.30 p.m.
Clinical Session at 7.30 p.m.

At Children's Hospital—
1st Wednesday.
Luncheon at 12.30 noon.
Ward Rounds 11.30 a.m. each Thursday.

At Grace Hospital—
3rd Tuesday.
Luncheon at 12.30 p.m.
Discussion of Obstetrical Cases will form a large part of the clinical hour.

At Misericordia Hospital—
2nd Tuesday at 12.30 p.m.

At St. Boniface Hospital—
2nd and 4th Thursdays.
Luncheon at 12.30. Meeting at 1.00 p.m.
Ward Rounds 11.00 a.m. each Tuesday.

At St. Joseph's Hospital—
4th Tuesday.
Luncheon at 12.30. Clinical Session 1.00 to 2.00 p.m.

At Victoria Hospital—
4th Friday.
Luncheon at 12.00. Meeting at 1.00 p.m.

At Winnipeg General Hospital—
1st and 3rd Thursdays.
Luncheon at 12.30. Clinical Session 1.00 to 2.00 p.m.
Ward Rounds 10.00 a.m. each Thursday.
Pathological Conference at Medical College at 9.00 a.m. Saturday during college term.

Winnipeg Medical Society—
3rd Friday, Medical College, at 8.15 p.m.
Session: September to May.

Eye, Ear, Nose and Throat Section—
1st Monday at 8.15 p.m., at 101 Medical Arts Building.

Relative Values of Carbohydrates

New Findings → *Confirm Old Truths*

Recent scientific investigations in rats (tabulated at the right) are in accord with many years of clinical observations on babies, as shown by the following excerpts from authoritative medical literature reflecting the consensus of three decades of pediatric experience.

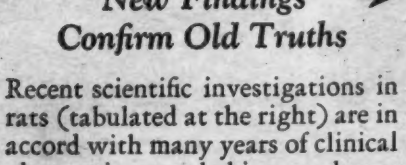
RELATIVE ASSIMILATION VALUES OF VARIOUS CARBOHYDRATES[1]

		Average per 100 gms. body weight
1	MALTOSE	1.50
2	DEXTRIN + MALTOSE	1.32
3	Glucose + dextrin	1.32
4	Glucose + sucrose	1.32
5	Glucose	1.04
6	Sucrose + maltose	0.98
7	Fructose + glucose	0.98
8	Sucrose + dextrin	0.76
9	Sucrose	0.76
10	Fructose	0.5
11	Glucose + lactose	0.26
12	Lactose	0.16
13	Galactose	0.1

These authors have also stated: "Maltose, fructose, glucose, starch and dextrin *lead* in nutritive value, *followed by* galactose, mannose, arabinose, xylose, lactose, sucrose and glycogen.[3]

[1] H. Ariyama and K. Takahasi: *Biochem. Z.*, 216:269 (1929) and [3] *J. Agr. Chem. Soc.*, Japan 5; 674 (1929).

CHART OF CARBOHYDRATE HYDROLYSIS[2]



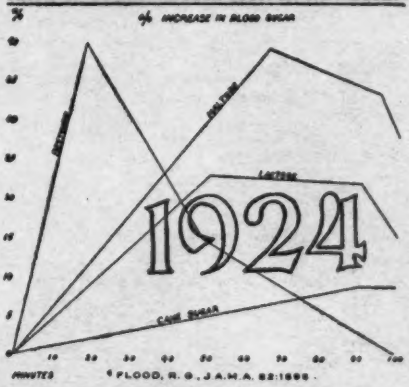
Note—The end product of maltose is all dextrose, which means quicker assimilation than end products from other carbohydrates.

*Monosaccharide **Disaccharide ***Polysaccharide

Maltose splits into two molecules of dextrose. Sucrose and lactose split into one molecule of dextrose and one of levulose or galactose respectively. It is no doubt due to the simpler structure of maltose that it is more readily absorbed than other sugars. It must also be considered that after assimilation the levulose of sucrose and the galactose of lactose must undergo conversion into dextrose, which is the only form in which sugar is present in the blood. It is reasonable to suppose that this conversion requires an expenditure of metabolic energy not required when carbohydrate is absorbed entirely in the form of dextrose.

[2] Morse, J. L. & Talbot, F. B. *Boston Med. & Surg. Jl.*, 189:852.

RATE OF SUGAR ABSORPTION IN NEWBORN[4]



[4] FLOOD, R. G., J.A.M.A. 82:1888.

MALTOSE OR LACTOSE IN INFANT FEEDING[5]

Answer—The superiority of one form of carbohydrate over another in artificial feeding of infants has been much discussed during recent years. It is generally accepted that cow's milk without modification is not a satisfactory infant food. So far as the carbohydrate is concerned, about one-fifth to one-eighth ounce per pound of infant's body weight is required daily. To supply this amount it is necessary to add carbohydrates in some form. Admitting that lactose is the sugar supplied in human milk, it does not follow that it is the sugar best tolerated in another medium, such as cow's milk. It is generally believed that lactose is more laxative than sucrose—that it must be fed with a certain amount of caution, as fermentative upsets are likely to follow if amounts approximating that found in human milk are fed. There is cause for disagreement among clinicians, as it is important to consider the other food elements; i.e., the amounts of fat and protein fed as well as the medium in which they are fed. For example, when lactic acid milk is used, more added carbohydrate seems to be tolerated than when sweet milk mixtures are fed. Sucrose has the advantage of being much cheaper and is always available. Evidence has not been presented that it should not be used in infant feeding. With its general use in large infant welfare clinics where supervision is a matter of routine, there is less to be said against it as far as clinical results are concerned. The complaint that it is too sweet is not often encountered when the usual amounts are fed. The dextrin-maltose preparations possess certain advantages. When they are added to cow's milk mixtures, we have a combination of three forms of carbohydrates, lactose, dextrin and maltose, all having different locations in the intestinal tract and different absorption rates. Because of the relatively slower conversion of dextrins to maltose and then to dextrose, fermentative processes are less likely to develop. Those preparations containing relatively more maltose are more laxative than those containing a higher percentage of dextrin (unless alkali salts such as potassium salts are added). It is common experience clinically that larger amounts of dextrin-maltose preparations may be fed as compared with the simple sugars. Obviously, when there is a lessened sugar tolerance such as occurs in many digestive disturbances, dextrin-maltose compounds may be used to advantage. [5] *Queries and Minor Notes, J. A. M. A.*, 83:266.